STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075403	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab West Haven	308 Savin Avenue West Haven, CT 06516

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility policy and staff interviews for 2 of 5 residents (Resident #21 and Resident #29) reviewed for unnecessary medications, the facility failed to obtain consent from the resident's representative for psychotropic medications and informed the resident's representative in advance of risk and benefits of psychotropic medication usage. The findings included: 1.Resident # 21's diagnoses included anxiety disorder, dementia, and borderline personality disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 was moderately cognitively impaired and required assistance of 2 or more helpers with showering, personal hygiene, upper and lower body dressing, and transfers. The MDS further identified Resident #21 had verbal behavioral symptoms directed toward others, and noted antipsychotics received on a routine basis. The Resident Care Plan (RCP) dated 6/13/25 identified psychiatric drug use and at risk for potential adverse effects of psychotropic drug use. Interventions included: to be aware of any signs of tremors or shaking, drowsiness, agitation, nausea, mood, behavior, dizziness, and have the medical doctor evaluate effectiveness and to identify side effects of medications for possible decrease/elimination of psychotropic drugs. A physician's order dated 7/22/25 directed to give Risperdal 1.0 Milligram (MG) two times a day for agitation and to notify the Advanced Practice Registered Nurse (APRN) or Psychiatric APRN for medication being held due to sedation. On 8/13/25 at 1:15 PM first request for psychotropic medication signed consent form for Resident #21 from Registered Nurse (RN#8). Consent was not provided. On 8/14/25 at 2:14 PM second request for psychotropic medication signed consent form for Resident #21 from RN #8. Consent was not provided. Interview with RN #8 on 8/14/25 at 2:14 PM identified signed consent forms for psychotropic medications were in the psychiatric consultant company notes. Resident #21 consent form was not available despite several requests for the form. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Psychotropic Medication Use Policy revised on 3/1/25 directed, in part, facility should involve the resident or the resident's representative in discussion of potential non-pharmacologic and medication interventions to address the management of behaviors. The involvement should be documented in the resident's medical record. Facility staff should inform the residents and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications. 2. Resident #29's diagnoses included unspecified dementia, Type 2 diabetes mellitus, chronic kidney disease. The quarterly Minimum Data Set assessment (MDS) assessment dated [DATE] identified Resident #29 was cognitively impaired and required maximal assistance with toilet transfers and hygiene and supervision assistance with eating. The MDS additionally noted the utilization of antipsychotic and antidepressant medications. A physician's order dated 6/24/25 directed to give 1.0 MG of Risperidone by mouth in the morning. The care plan dated 7/5/25 identified Activities of daily living (ADL). Interventions included to assist with preforming ADL as needed. Review of Residents #29's clinical record failed to reflect a consent form notifying the resident's representatives of risk and benefits of the utilization of psychotropic medications. Interview with 8/14/2025 2:14 PM with Medical Doctor # 2 indicated the consent was not available. She reported consents in the psychiatric notes but was unable to locate. Interview with RN#3 identified she/he was able to locate a psychiatric note dated 8/5/25 indicating Resident #29 consented (resident has impaired cognition, diagnosis of dementia and is conserved). After inquiry of Resident # 29's ability to give consent, RN 3 indicates she/he could not provide evidence Resident # 29's conservator consented to the medication and could not explain why the resident was given a consent form.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on clinical record review and staff interviews for 1 of 3 employee files reviewed for Nurse Aide (NA # 8), the facility failed to conduct a thorough investigation on the history of prospective staff, including required background checks, prior to the hire date. The findings include: On 8/14/2025 at 12:55 PM, an interview and review of employee files with the Human Resources Director identified NA#8 was hired on 4/12/2024. She was certified as a nursing aide since 3/07/2023. Although NA#8's employee file contained signed employee consents for background checks, the file did not contain documentation of a completed state or federal background check, including fingerprint-based screening through the Applicant Background Check Management System (ABCMS). The Human Resources Director indicated she was unable to retrieve evidence of an ABCMS screening on the online portal. The Human Resource Director indicated background checks, including the ABCMS screening, are done by the facility prior to employing staff and could not identify a reason for NA#8 not having one. Furthermore, the Human Resource Director indicated NA#8 would be removed from the schedule until NA#8 completes an ABCMS screening. On an interview on 8/14/2025 at 1:35 PM, the Administrator could not explain why NA # 8 did not have a background check or an ABCMS screening prior to being hired. The Administrator indicated that when the Human Resource Director began working at the facility, she had been auditing employee records, and the facility would ensure employee records are audited for background checks. Although requested, the facility was unable to produce a policy for pre-employment screening. However, the facilities abuse policy given during the survey identified a section for pre-hire screening, which indicated the facility would ensure an active license or certification and would review regulatory action reports. The abuse policy did not identify a process for ensuring background checks and ABCMS screenings were completed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documents, policy review and staff interviews for 1 of 6 residents reviewed for abuse (Resident # 2), the facility failed to follow up on and report a potential allegation of abuse. The findings include: Resident #2's diagnoses included quadriplegia (paralysis of all four extremities), anxiety, and depression. The Medicare 5-day MDS assessment dated [DATE] identified Resident #2 was cognitively intact and had not exhibited behavioral symptoms towards self or others. The MDS assessment further indicated Resident #2 was dependent for toileting and bathing and always incontinent of bowel. A care plan dated 7/9/2025 identified Resident #2 required total assistance for activities of daily living (ADL). Interventions included the assistance of one staff member with incontinence care and using a hands-free system to use the call light. 0n 8/6/2025 at 3:20 PM during a screening interview, Resident #2 indicated that 3 to 4 months ago, a nursing aide whose name she/he did not recall came in during a morning shift around 11:00 AM to provide a bath. Resident #2 indicated he/she refused care, but the nursing aide proceeded to wash him/her anyway. Resident #2 indicated she/he complained to his/her nurse that day (LPN#1) and to the DNS at the time (RN#5). Resident #2 indicated she/he had not seen the nurse aide again since the incident and indicated she/he did not know what LPN#1 and RN#5 had done about the incident. On 8/11/2025 at 11:00 AM, an interview with LPN #2, who was taking care of Resident #2, indicated she had heard about the incident but could not recall from where. LPN # 2 further indicated she did not know any details. However, LPN#2 indicated she thought it had occurred on a weekend when she was off. On 8/11/2025 at 11:44 AM, an interview with LPN#1 identified that sometime in the end of March 2025 or April 2025 (LPN#1 could not recall the exact date), NA#8 came to her to inform her that Resident #2 was refusing care from NA#8. LPN#1 indicated she spoke to Resident #2, who indicated NA#8 was trying to change him/her against his/her will. Additionally, LPN#1 indicated Resident #1 had informed her that NA#8 had changed him/her against his/her will during the night therefore she/he want NA#8 taking care of him/her anymore. LPN#1 indicated she had the nursing aides switch assignments so NA#8 would not be assigned to Resident #2 and then informed RN#5 about the resident's concern. LPN#1 did not recall which nursing aide took over Resident #2's care. LPN#1 indicated that when there is an allegation of abuse, staff are supposed to contact the DNS, and the DNS handles things from there. LPN#1 further indicated that she did not follow up with the resident afterwards and did not recall if the DNS had spoken to Resident #2 after being informed. LPN#1 indicated she did not tell the supervisor of the shift because she had already told the DNS. On 8/11/2025 at 12:23 PM, an interview with the Administrator indicated he was not aware of an incident between NA#8 and Resident #2. The Administrator also identified RN#5's last day working as a DNS was on 6/30/2025 and the current DNS served as Assistant Director of Nursing Services (ADNS) from 5/15/2025 to 7/21/2025 and then assumed DNS role on 7/22/2025. On 8/11/2025 at 2:18 PM, an interview with RN#5 identified RN#5 did not recall an incident between NA#8 and Resident #2 and indicated that had there been an incident, she would have written an incident report. The written report would been left on her desk after she left the facility. RN#5 indicated that when there was an allegation of staff-to-resident abuse, the process included: staff write statements, notifying the social worker, and removing the staff member from the schedule pending investigation. A review of nursing notes and social work notes from 3/15/2025 to 5/30/2025 failed to identify an incident where Resident#2 refused care and complained of being provided peri care against his/her will. A review of facility accident and incident reports from 1/1/2025 to 8/6/2025 for Resident #2 failed to identify an incident between NA#8 and Resident #2 or any other incident of potential abuse. A review of the facility's state's reportable events data since the last recertification survey on 12/21/2023 failed to identify an allegation of abuse for Resident #2. On 8/13/2025 at 10:30 AM, an interview with the DNS indicated she was not aware of an incident between Resident #2 and NA#8, but indicated that if a resident refuses care, staff should document it and reapproach later. Additionally, the DNS indicated there were no other incident and accident reports for Resident #2 from 1/1/2025 to 8/6/2025 other than what was already provided. On 8/14/2025 at 9:13 AM, an interview with NA#8 identified NA#8 denied providing care to Resident #2 without his/her consent. NA#8 did indicate that there was an incident a few months prior (NA#8 could not recall the exact day or month) where she was providing incontinence care to Resident #2 after Resident #2 had agreed to be peri care, but Resident #2 complained that NA#8 was taking too long and yelled at her to stop and leave. NA#8 indicated she stopped and reported to LPN#1 the resident did not want her/him (NA #8) taking

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Apple Rehab West Haven	308 Savin Avenue West Haven, CT 06516

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documents, policy review and staff interviews for 1 of 6 residents reviewed for abuse (Resident # 2), the facility failed to conduct a thorough investigation regarding an allegation of mistreatment. The findings include: Resident #2's diagnoses included quadriplegia (paralysis of all four extremities), anxiety, and depression. The Medicare 5-day MDS assessment dated [DATE] identified Resident #2 was cognitively intact and had not exhibited behavioral symptoms towards self or others. The MDS assessment further indicated Resident #2 was dependent for toileting and bathing and always incontinent of bowel. A care plan dated 7/9/2025 identified Resident #2 required total assistance for activities of daily living (ADL). Interventions included the assistance of one staff member with incontinence care and using a hands-free system to use the call light. 0n 8/6/2025 at 3:20 PM during a screening interview, Resident #2 indicated that 3 to 4 months ago, a nursing aide whose name she/he did not recall came in during a morning shift around 11:00 AM to provide a bath. Resident #2 indicated he/she refused care, but the nursing aide proceeded to wash him/her anyway. Resident #2 indicated she/he complained to his/her nurse that day (LPN#1) and to the DNS at the time (RN#5). Resident #2 indicated she/he had not seen the nurse aide again since the incident and indicated she/he did not know what LPN#1 and RN#5 had done about the incident. On 8/11/2025 at 11:00 AM, an interview with LPN #2, who was taking care of Resident #2, indicated she had heard about the incident but could not recall from where. LPN # 2 further indicated she did not know any details. However, LPN#2 indicated she thought it had occurred on a weekend when she was off. On 8/11/2025 at 11:44 AM, an interview with LPN#1 identified that sometime in the end of March 2025 or April 2025 (LPN#1 could not recall the exact date), NA#8 came to her to inform her that Resident #2 was refusing care from NA#8. LPN#1 indicated she spoke to Resident #2, who indicated NA#8 was trying to change him/her against his/her will. Additionally, LPN#1 indicated Resident #1 had informed her that NA#8 had changed him/her against his/her will during the night therefore she/he want NA#8 taking care of him/her anymore. LPN#1 indicated she had the nursing aides switch assignments so NA#8 would not be assigned to Resident #2 and then informed RN#5 about the resident's concern. LPN#1 did not recall which nursing aide took over Resident #2's care. LPN#1 indicated that when there is an allegation of abuse, staff are supposed to contact the DNS, and the DNS handles things from there. LPN#1 further indicated that she did not follow up with the resident afterwards and did not recall if the DNS had spoken to Resident #2 after being informed. LPN#1 indicated she did not tell the supervisor of the shift because she had already told the DNS. On 8/11/2025 at 12:23 PM, an interview with the Administrator indicated he was not aware of an incident between NA#8 and Resident #2. The Administrator also identified RN#5's last day working as a DNS was on 6/30/2025 and the current DNS served as Assistant Director of Nursing Services (ADNS) from 5/15/2025 to 7/21/2025 and then assumed DNS role on 7/22/2025. On 8/11/2025 at 2:18 PM, an interview with RN#5 identified RN#5 did not recall an incident between NA#8 and Resident #2 and indicated that had there been an incident, she would have written an incident report. The written report would been left on her desk after she left the facility. RN#5 indicated that when there was an allegation of staff-to-resident abuse, the process included: staff write statements, notifying the social worker, and removing the staff member from the schedule pending investigation. On 8/13/2025 at 10:30 AM, an interview with the DNS indicated she was not aware of an incident between Resident #2 and NA#8, but indicated that if a resident refuses care, staff should document it and reapproach later. Additionally, the DNS indicated there were no other incident and accident reports for Resident #2 from 1/1/2025 to 8/6/2025 other than what was already provided. On 8/14/2025 at 9:13 AM, an interview with NA#8 identified NA#8 denied providing care to Resident #2 without his/her consent. NA#8 did indicate that there was an incident a few months prior (NA#8 could not recall the exact day or month) where she was providing incontinence care to Resident #2 after Resident #2 had agreed to peri care, but Resident #2 complained that NA#8 was taking too long and yelled at her to stop and leave. NA#8 indicated she stopped and reported to LPN#1 the resident did not want her/him (NA #8) taking care of him/her anymore. NA#8 indicated she could not recall which nursing aide switched assignments with her that day. The facility policy for Abuse notes any staff suspecting abuse should immediately report it to the supervisor, who would then report it to the DNS and the Administrator. Additionally, the policy directed the Administrator, DNS, or designee would initiate an investigation. The Abuse policy further indicated that an investigation would include interviews of all witnesses, including the accused, interviews with any individual

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, facility documentation, facility policy and interviews for 1 resident (Resident #57) reviewed for pain, the facility failed to ensure a comprehensive assessment was completed timely. The findings include: Resident #57 ‘s diagnoses included Unilateral Primary Osteoarthritis, presence of artificial right knee and lower back pain. The clinical record identified Resident #57 as cognitively intact. The care plan dated 7/21/25 identified pain. Interventions included providing medications as ordered A physician's order dated 8/8/25 directed to ice packs to right knee every 3 hours for 20 minutes at a time to reduce swelling. Interview with MDS Coordinator #1 on 8/13/2025 at 10:46 AM reported for newly admitted residents the MDS should be completed on or before 14 days after admission. She further indicated the MDS coordinator is responsible for doing so and as of 8/1/25 the MDS was identified as late. She was unsure why the MDS was not completed. Facilities [NAME] Planning policy indicates in part that A comprehensive and individualized plan of care will be developed for each resident. The policy did not speak to the MDS completion process.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, facility policy review and staff interviews for the only resident reviewed for accidents (Resident #17) and 1 of 2 residents (Resident #17) reviewed for Activities of Daily Living, the facility failed to ensure staff updated the resident care plan after a fall and revise the care plan to reflect the resident's oral care needs and preferences and for 1 of 3 residents (Resident #82) reviewed for respiratory care, the facility failed to revise and update care plan to reflect oxygen use and interventions. The findings included: 1.Resident #17's diagnoses included schizophrenia and dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #17 was moderately cognitive impaired. The care plan dated 6/12 2025 with updated 7/22/2025 indicated Resident #17was at risk for falls due to newly admitted to the facility indicating Resident #17 fell on 5/24/2024, 2/7/2025, 4/19/2025 and 7/22/2025. Interventions included in part to offer toileting after each meal, encouraging asking and waiting for assistance and staff to conduct frequent checks. The care plan further indicated Resident #17 required assistance with activities of daily living. Interventions included in part to provide dental services as ordered and needed. The care plan further indicated Resident #17 can be resistive to washing hands, showering, refusal of care and following physician's orders. Interventions included, in part, if Resident #17 refuses care to leave and return in 5-10 minutes and to praise desired behavior. A facility Reportable Event form dated 6/21/2025 indicated Resident #17 was found on the floor(fall) unconscious with a hematoma to the right cheekbone, regained consciousness before being sent to the hospital for an evaluation. The Fall Scene investigation page 3 of the report was noted to have a complete brief description of the residents' state prior to the fall and the resident/room check after the fall. The Fall Huddle/Root Cause of Fall, intervention to prevent future falls, update of the care plan and care card were not completed and the area for the supervisor's name and signature who completed the fall scene investigation remained blank. A dental exam note dated 7/07/2025 indicated, in part, Resident #17 was missing some teeth had moderate plaque/food debris buildup, moderate gingivitis/swollen bleeding gums and moderate hard calcium deposits condition of teeth were fair with no symptoms. Nursing home staff action requirements was to continue with oral care. An observation on 8/6/2025 at 11:33 AM identified Resident #17 at 9:50 AM was noted sitting in a chair outside the nurse's station, confused but smiling. Resident #17's teeth were noted to have a build up along gumlines with white material. An observation on 8/7/2025 at 10:07 AM Resident #17 was noted to have the same white buildup on upper and lower gumline/teeth. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/2025 at 9:33 AM attempts to reach RN #6, the nursing supervisor on duty at the time of the fall were unsuccessful. On 8/12/2025 at 10:22 AM an interview, record and facility document review with the Director of Nursing Services (DNS) indicated during the time of the fall management changes that happened administrative staff was behind in revieing incident reports leading to not seeing incomplete areas on the document. The DNS further indicated she/he was unable to provide revision of the care to address the residents fall or after return from the hospital to meet resident needs post fall. Additionally, there are no revisions for interventions to prevent further falls. The DNS indicated the nursing supervisor was responsible for revising the care plan. An observation on 8/12/2025 at 10:55 AM identified Resident #17 with white build up on the top and bottom gumline still noted. On 8/12/2025 at 11:00AM an interview and observation with Resident #17's regular nurse aide. (NA #6) indicated Resident #17 has dementia She gets up before breakfast in the AM but still wants to do oral care by him/ herself but NA # 6 assist with setting up the resident with the supplies needed and assist when needed. The buildup of white debris at the gumline NA#6 indicated possibly could be the oral tablet she gets from the nurse that dissolves in the resident's mouth. An interview and record review with the Nursing Supervisor, RN # 4 on 8/12/2025 at 11:05 AM indicated the care plan directed to see a dentist as needed and resident was seen by the hygienist recently. RN #4 further indicated the care plan should have been updated with the resident's oral care needs and preferences regarding wanting to provide own care. RN #6 further indicated s/he would update the care plan based on the dental evaluation and with the resident preferences. The facility policy labeled Care Planning indicated in part, a comprehensive care plan will be developed based on identified needs, strengths, and preferences of the resident and developed by the interdisciplinary team. The care plan is reviewed and updated at least quarterly and necessary to reflect changes in the residents' status. 2. Resident # 82's diagnoses included Acute Respiratory Failure with Hypoxia, acute respiratory failure with hypercapnia and anxiety. Review of the W10 (Intra-Agency Discharge Summary) indicated Resident #82 was admitted to hospital 4/20/25 due to (Principal) hypoxia Acute hypoxic respiratory failure. Resident #82 W10 physician's orders indicated the resident requires oxygen due to diagnosis of severe lung disease or hypoxia liter flow of 2L continuous. A physician's order dated 5/16/25 directed to taper off oxygen gradually, maintaining oxygen saturation of >90 and to monitor every shift. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #82 was cognitively intact and required supervision /set up assistance for personal hygiene, oral hygiene and partial assistance for bed mobility. The MDS did not indicate Resident #82 was receiving oxygen. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident care plan dated 6/10/25 identified Cardiovascular Disease Interventions included to check oxygen saturation as ordered/as needed/per policy (created 1/14/22). The care plan does not identify intervention for oxygen specifically. Observations on 8/6/2025 at 12:43 PM of Resident #82 identified the resident in room with nasal canula flowing at 1.5 L. while making the observation Resident #82 reported it supposed to be on 2. Observation on 8/7/2025 at 9:28 AM of Resident #82 on nasal cannula at a 1.5 L flow. Resident #82 reported he/she has been on oxygen since returning to the facility from the hospital (4/30/25). Interview with DNS on 8/14/25 at 1:50 PM indicated that if a resident is on oxygen, the care plan should be updated to include interventions for that care. She also indicated the nursing team is responsible for ensuring this process is done. The DNS was unable to explain why the care plan did not reflect interventions for oxygen utilization. Facilities care planning policy (revised 10/30/20) indicates in part The care plan is revised and updated at least quarterly and as necessary to reflect changes in the resident status.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab West Haven	308 Savin Avenue West Haven, CT 06516

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review, policy review and interview for 1 of 5 residents (Resident #17) reviewed for unnecessary medications, the facility failed to transcribe physician's order. The findings included:Resident #17's diagnoses included schizophrenia, dementia, and anxiety.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #17 had a Brief Interview of Mental Status (BIMS) score of 8 indicating moderate cognitive impairment and noted the resident required setup for eating. The assessment also noted the resident required partial/moderate assistance for dressing and transfers.The Resident Care Plan dated 7/22/25 identified Resident #17 had schizophrenia disorder and was at risk for changes in mood state and behaviors. Interventions included follow up by psychiatry group and to administer medications as ordered.The Psychiatry APRN progress note dated 7/28/25 at 6:53 AM identified Resident #17 was seen at the request of the facility for behavior disturbances, with an increase in confusion, agitation and combativeness during care. Verbal redirection was not effective, and nursing suspected a urinary tract infection. Physician's orders subsequent to the visit included starting Seroquel 25 mg (anti-anxiety) by mouth as needed every 12 hours for 14 days for acute anxiety, agitation, combative behaviors and then re-evaluate (hold for sedation), blood work: Depakote level, Complete Blood Count (CBC) with diff, Comprehensive Metabolic Panel (CMP) and urine culture and sensitivity. A written physician's order sheet located in Resident #17's chart dated 7/25/25 identified the psychiatry group APRN had ordered to start Seroquel 25mg by mouth every 12 hours as needed for agitation, combative behaviors, and then reevaluate after 14 days. As well as blood work for Depakote level, CBC with diff and CMP and a urine culture with sensitivity. The physician's order sheet identified a line under the orders, with the word noted as well as initials of Registered Nurse Supervisor (RN) #1 (identified by RN #2, multiple attempts were made to interview RN #1 with no call back). A review of the active or completed physician's orders on 8/13/25 failed to identify an order for Seroquel 25 mg every 12 hours as needed for 14 days or an order for a urine sample to be obtained. Interview and record review with RN Supervisor #2 on 8/13/25 at 12:56 PM identified it was the facility policy for the charge nurse or supervisor to follow through on the handwritten physician's order sheet. This was done by transcribing the orders in the electronic health record (medication, laboratory etc.), then drawing a line under the orders, the word noted and initialing next to the line to confirm the orders were transcribed and followed up on. A review of Resident #17's chart with RN #2 identified RN #1 noted the 7/25/25 physician's orders written by the psychiatry APRN were transcribed. (Multiple attempts were made to interview RN #1 with no call back). However, a review of the electronic health record with RN #2 identified only the order for laboratory work was transcribed, and but failed to identify the medication (Seroquel 25mg by mouth every 12 hours as needed for agitation, combative behaviors, and then reevaluate after 14 days) order or the urine culture with sensitivity order was ever transcribed into the electronic health record. Additional clinical record review of the laboratory book (a book used to convey blood work and specimens needed by laboratory) with RN #2 identified that although the blood work was requested on 7/28/25, a urine sample pick up was never set up for pick up. RN #2 could not identify why the medication and urine specimen orders were not transcribed (even though the physician's order sheet identified them as noted).Although a Physician's Orders Policy was requested, it was not provided by the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy and interviews for 2 of 6 residents reviewed for abuse, the facility failed to ensure Resident #29 was provided care in a timely manner. The findings include: Resident #29 ‘s diagnoses included unspecified dementia, Type 2 diabetes mellitus, chronic kidney disease. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #29 was moderately cognitively impaired and required maximal assistance with toilet transfers and hygiene, the MDS also indicates Resident #29 has frequent urinary incontinence and occasionally incontinence of the bowel. The care plan dated 10/7/25 for Activities of daily living (ADLs). Interventions included assisting with preforming ADL as needed and transferring per physician's order. A physician's order dated 4/16/25 directed Resident #29 requires assistance of one staff for transfers.Observation on 8/7/2025 at 9:32 AM of Resident #29 requesting to use bathroom identified Nurse Aide (NA # 3) responded to the resident she would be right with him/her.Observation on 8/7/2025 at 9:50 AM of Resident #29 still in hallway, unattended too.Observation on 8/7/2025 at 10:07 AM of Resident #29 still sitting by nursing station unattended to by staff regarding his/her bathroom request. Observation on 8/7/2025 at 11:38 AM resident still sitting in hall by the nursing station. Interview with NA#3 on 8/7/25 at 10:25 AM identified if a resident request to use the bathroom, they are attended to as soon as they request to go to the bathroom. NA#3 identified if staffs is in middle of care, then other staff members would assist. She reported waiting beyond 2 hours would be considered a long period of time. Interview with Person #1 on 8/7/25 at 10:51AM identified he/she visited yesterday (8/6/25) and the resident was wet from urination. She/he reported she believes the facility being short staffed is a direct result of Resident #29 not getting toileted on time. Observation on 8/7/25 at 11:45AM of Resident #29's second requested to use the bathroom. Licensed Practical Nurse (LPN#3) responded that she will get his/her NA to help. Observation of NA#4 on 8/7/25 at 11:47 taking Resident #29 to bathroom. Interview with NA #4 indicated if a resident requests to use the bathroom any available nursing staff can take him or her. However, they should inform the assigned NA. She reported Resident #29 is assigned to her and this was the first time today someone informed her that the resident needed to use the bathroom. She reported LPN #3 informed her moments before now.Interview with LPN#3 on 8/7/25 at 11:50 indicated that if a resident request to use the bathroom, it is expected that they are assisted as soon as possible. Review of the Nurse Aide task indicated a toilet transfer for 12:10 PM. Interview with DNS on 8/13/2025 at 9:45 AM indicated 15 minutes reasonable amount of time to go to bathroom. She reported that the nurse aides are responsible for ensuring residents are taken to bathroom.Facilities Assisting a resident with toileting policy indicated in part that the prepose of the procedure is to assist the residents with ambulating to bathroom.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical records and policy review for 1 of 1 resident (Resident #17) reviewed for edema, the facility failed to obtain weekly weights per physician's order and for 1 of 2 residents (Resident #8) reviewed for medication administration the facility failed to ensure a resident's medication was made available and for 3 of 3 residents (Resident #1, Resident #31, Resident #38) reviewed for physician orders, the facility failed to ensure medications were administered timely and in accordance to physician orders and 1 of 5 residents reviewed for Unnecessary Medication (Resident # 29), facility failed to ensure that medications were administered per physician's orders. The findings included: 1.Resident #17's diagnoses included dysphagia, gastroesophageal reflux disease and rhabdomyolysis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #17 had a Brief Interview of Mental Status (BIMS) score of 8 indicating moderate cognitive impairment and was a setup for eating and partial/moderate assistance for dressing and transfers. The physician's order dated 7/15/25 directed for weekly weights to be obtained every Monday. The Resident Care Plan dated 7/22/25 identified Resident #17 had potential for a nutritional decline related to multiple medical problems, need for a therapeutic diet and need for altered consistency diet. Interventions included providing supplements as ordered and to weigh as ordered. A review of the weight report identified Resident #17 had a weight obtained on 8/7/25, without the benefit of weekly weights since the physician's order was initiated on 7/15/25. A review of the nurse's notes dated 7/15/25 through 8/13/25 failed to identify Resident #17's refusal of getting a weight. Interview and record review with Nursing Assistant (NA) #2 on 8/13/25 at 9:22 AM identified the nursing assistants are responsible for obtaining resident weights, which are done monthly. Additionally, any resident who gets a weigh more frequently is identified on the Weights List posted at the nurse's station. A review of the posted Weights List with NA #2 directed for Resident #17 to be weighed monthly. Interview and clinical record review with RN Supervisor (RN) #1 on 8/13/25 at 9:54 AM identified the facility policy on weights was for NA's to obtain them on admission, then weekly for four weeks and then per physician's order. A review of Resident #17's clinical record identified she/he had a physician's order for weekly weights starting 7/15/25, with the only weight obtained on 8/7/25. RN #1 could not identify why the weights were not obtained weekly per physician's order. Subsequent to surveyor inquiry RN #1 obtained a weight for Resident #17, who was witnessed to be cooperative with the weight request. Review of the Weight Monitoring Policy directed in part that accurate and timely measurement of weight change in all residents is an important tool in assessing their nutritional status. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. a. Resident #8's diagnoses included spina bifida, paraplegia, and stage 4 pressure ulcer of the sacral region. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 was cognitively intact and required the assistance of 2 or more people with bed mobility, toilet hygiene, and transfers. Observations of medication administration on 8/6/25 at 9:38 AM with Licensed Practical Nurse (LPN #1) for Resident #8 identified the clotrimazole-betamethasone cream was not available in the facility. Interview with LPN#1 on 8/6/25 at 10:29 AM identified Resident #8's clotrimazole-betamethasone cream was not located in the medication cart or in the medication room, and she would fill out a paper pharmacy re-order form and fax to pharmacy, and the cream should be delivered the next day. Interview on 8/7/25 at 9:35 AM with LPN #2 identified she was taking care of Resident #8 and administered her/his morning medications but could not locate the clotrimazole-betamethasone cream. LPN #2 placed a second pharmacy re-order request electronically through via computer. It was further identified the paper pharmacy re-order form for the cream was faxed to the pharmacy on 8/6/25 at 10:56 PM and would not be delivered until later in the afternoon on 8/7/25. Interview on 8/7/25 at 10:36 AM with the DNS identified residents' medications should be re-ordered by the nurse when the quantity gets down to approximately a seven-day supply, and the medication would get delivered the same day if it was re-ordered or the next day, depending on the time of day requested. The DNS further identified, the physician should be notified when medications are not available or given to a resident. Review of Resident #8's Medication Administration Record (MAR) on 8/11/25 at 12:15 PM identified Resident #8 did not receive the clotrimazole-betamethasone cream and missed applications scheduled for 8/6/25 in the morning and in the evening and missed on 8/7/25 in the morning. Interview on 8/11/25 at 12:36 PM with LPN #1 identified that she filled out a paper medication re-order form for Resident #8's clotrimazole-betamethasone cream on 8/6/25 in the morning but did not fax it to the pharmacy until 10:56 PM on 8/6/25 at the end of her double shift. LPN #1 did not recall if the physician was notified. Interview on 8/13/25 at 2:05 PM with Person #3 identified the pharmacy received a paper re-order on 8/6/25 at 10:56 PM and another electronic re-order request on 8/7/25 at 9:38 AM and Resident #8's clotrimazole-betamethasone cream was delivered on 8/7/25 at 4:26 PM. Review of the Medication Administration Policy V1 dated 2025 directed, in part, the physician must be notified when a dose of medication has not been given, and an explanatory note is entered on the reverse side of the record provided when needed documentation. b. Resident #1's diagnoses included non-Hodgkin lymphoma, anxiety disorder, and dementia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] identified Resident #1 was severely cognitively impaired and required maximal assistance (helper does more than half the effort) with oral hygiene, showers, personal hygiene, upper and lower body dressing and required the assistance of 2 or more helpers with transfers. The physician's orders; dated 4/15/25 directed to administer escitalopram oxalate oral 10 milligram (MG) tablet one time a day for depression, trazodone HCl 50 MG tablet two times a day for agitation, and polyethylene glycol powder 17 gram (G) two times a day for constipation, dated 4/18/25 directed to administer oxycodone HCl 5 MG tablet two times a day for pain, dated 6/25/25 directed to administer Dulcolax 5 MG tablet one time a day for constipation, and dated 8/4/25 directed to administer lactulose 15 milliliters (ML) two times a day for constipation. Scheduled medication administration times in Resident #1's MAR was 9:00 AM. c. Resident #31's diagnoses included diabetes mellitus, congestive heart failure, anxiety disorder, and depression. The quarterly MDS assessment dated [DATE] identified Resident #31 was moderately cognitively impaired and required maximal assistance with toileting hygiene, personal hygiene, lower body dressing, and transfers. The physician's orders; dated 1/18/24 directed to offer dairy or cola with meals related to low phosphorus level, scheduled at 8 :00AM daily, dated 9/30/24 directed to instill 1 drop of refresh plus ophthalmic solution in both eyes two times a day for dry eyes scheduled for 9:00 AM, dated 10/1/24 directed to give 1 scoop of MiraLAX oral powder in the morning for constipation scheduled for 9:00 AM. The physician's orders dated 10/2/24 directed to give losartan potassium I tablet in the morning for hypertension scheduled for 9 :00AM, dated 10/2/24 directed to give metoprolol tartrate 12.5 mg two times a day for hypertension scheduled for 9:00 AM, dated 11/17/24 directed to give Norvasc 1 tablet in the morning for hypertension scheduled for 9:00 AM, dated 12/24/24 directed to give Nepro 240 ml in the morning scheduled for 8:00 AM, dated 4/11/25 directed to give linagliptin 5 MG one time a day for diabetes scheduled for 9:00 AM, dated 6/18/25 directed to give sevelamer carbonate 1 tablet three times a day for specialized treatment scheduled for 9 AM, dated 6/30/25 directed to give Eliquis 5 MG tablet two times a day related to cerebral infarction (stroke) scheduled for 9:00 AM. The physician's orders dated 7/1/25 directed to give protonix 1 tablet one time a day for gastroesophageal reflux (heartburn) prior to breakfast scheduled at 8:00 AM, give clopidogrel bisulfate 75 MG in the morning for prophylaxis (prevention) scheduled for 9:00 AM, dated 7/15/25 directed to give cinacalcet HCl 90 MG one time a day scheduled at 9:00 AM, dated 7/16/25 directed to give gabapentin 1 capsule two times a day scheduled for 9:00 AM, and dated 7/21/25 directed to give doxycycline hyclate 100 MG two times a day for foot wound scheduled at 9:00 AM. Scheduled medication administration times in Resident #31's MAR was 8:00 AM and 9:00 AM. d. Resident #38's diagnoses included hepatic (liver) failure, malignant neoplasm (cancer) of prostate, and hypertension. The quarterly MDS assessment dated [DATE] identified Resident #38 was cognitively intact and required setup or clean-up assistance for eating, toileting hygiene, personal hygiene, and transfers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's orders dated 3/31/22 directed to give magnesium oxide one time a day for supplement. The physician's orders dated 4/6/22 directed to give B-1 100 MG tablet one time a day for nutrition, cyanocobalamin 1000 microgram (MCG) tablet one time a day for vitamin, and folic acid 1 MG tablet one time a day for anemia. The physician's 7/29/22 directed to give Lasix 40 MG tablet one time a day for diuretic, dated 10/3/24 directed to give Norvasc 2.5 MG tablet in the morning for hypertension (high blood pressure). The physician's orders 1/14/25 directed to give tamsulosin HCl 0.4 MG two times a day for prostate. Scheduled medication administration times in Resident #38's MAR was 9:00AM. Observation on 8/12/25 at 11:04 AM identified LPN #8 at her medication cart administering medications in the third-floor hallway to Resident #1, Resident #31, and Resident #38. Interview with LPN #8 on 8/12/25 at 11:09 AM identified she administered medications that were scheduled for 8:00 AM and 9:00 AM to Resident #1, Resident #31, and Resident #38 at 11:04 AM. LPN #8 identified she administered the medications past the scheduled time because she came into work at 8:00 AM to help and she did not notify the physician the medications were late. Review of Resident #1, Resident #31, and Resident #38's MAR on 8/13/25 at 10:00 AM, identified medications administered on 8/12/25 at 11:04 AM were signed off in the computer given by LPN #8 at 8:00 AM and 9:00 AM timeframes. Interview with DNS on 8/13/25 at 10:30 AM identified per the facility's medication administration policy, medications can be administered one hour before scheduled time and one hour after scheduled time, and the clinician should be notified. The DNS also indicated a nurse should not have given 8:00 AM and 9 :00AM scheduled medications at 11:04 AM but should have an order for that time given. Review of the Medication Administration and General Guidelines Policy dated 2025 directed, in part, medications are administered within one hour of the scheduled time, unless the physician specifies a specific time, before and after meal orders are administered precisely as ordered. 3. Resident #29 's diagnoses included Unspecified dementia, Type 2 diabetes mellitus, chronic kidney disease. A physician's order dated 4/16/25 directed Resident #29 requires assistance of one staff for transfers The quarterly Minimum Data Set assessment (MDS) assessment dated [DATE] identified Resident #29 was cognitively impaired and required maximal assistance with toilet transfers and hygiene and supervision assistance with eating. The care plan dated 7/5/25 identified Activities of daily living (ADL). Interventions included to assist with preforming ADL as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the August 2025 Medication Administration Record (MAR) indicated the following medications were missed on 8/8/25: DM Supplement 8oz once a day in the morning, Risperidone (anti-psychotic) to be given 1 mg by mouth in the morning, Eliquis (blood thinner) Oral Tablet 5 MG(Apixaban) to be given 1 tablet mouth two times a Day(this was not given in the morning), Metformin (anti-diabetic agent) HCl to be given 1 tablet by mouth two times a day, Tamsulosin HCl (treat prostate)Oral Capsule 0.4 MG (Tamsulosin HCl) to be given 1 capsule by mouth two times a day (this was not given in the morning), to give 240 ml clear liquids during medication pass every shift for hydration, pain assessment and behaviors were also not documented. Review of Nursing notes for 8/8/25 did not indicate Resident # 29 refused medications. Interview with DNS on 08/13/2025 1:08 PM indicated that medications are administered as prescribed. She further indicated if a resident were to refuse her/his medication, then it should be documented in notes or on the MAR. The DNS reported the charge nurse is responsible for ensuring that the MAR is completed and is unsure why the MAR is blank.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy and interviews for 2 of 6 residents reviewed for abuse, the facility failed to ensure Resident #35 received audiology follow up for missing hearing aids. (sensory device). The findings include:Resident #35's diagnoses included unspecified hearing loss, adjustments disorder, and age-related physical debility.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #35 was moderately cognitively impaired and noted dependent for upper body dressing, personal hygiene and toileting hygiene.The care plan dated 7/11/25 identified Activities of Daily Living (ADL). Interventions included to ensure Residents#35 hearing aids are in daily and are functioning properly and to make audiology appointments as ordered/needed. A Missing Property form dated 7/25/25 indicated, Resident #35 hearing aids were missing. Resolution indicated Interdisciplinary team added Resident to the Audiology list for new hearing aids. Observation on 8/12/25 at 9:45 AM of resident #35 in his/ her room without his/ her hearing aid. Resident#35 was unable to hearing this surveyor introducing themselves. Interview with LPN #2 on 8/12/2025 at 9:50 AM indicated that when a resident loses a hearing aid, the nursing team or the front desk attendant should add the resident to the audiology list. She reported this is done by faxing or calling the hearing vendor. She was unsure if Resident #35 was added to the audiology list. Interview with Social worker #1 on 8/12/2025 at 9:58 AM indicated that the family brought the missing hearing aids to her attention. She reports after filling out the missing property form, the DNS formulates a list of residents who needs to be seen by a specialist.Interview with DNS on 8/12/2025 at 10:02 AM indicated once she is informed of a missing item (like a hearing aid) she would reach out to health drive via email to place resident on the list.On 8/12/2025 at 10:39 AM the DNS reported she was unable to locate the email, which indicates residents required hearing services from vendor. She reported her transition and adjustment to her new role might be affecting the reason this was not implemented. Interview with the Hearing Aid vendor representative Person #2 on 8/12/2025 at 11:06 AM indicated that there are no residents on the audiology list to be seen nor are there any dates scheduled for audiology vendor to go out to that facility. The policy provided did not indicate expectation for ensuring missing items' concerns are resolved.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Number of residents sampled:0Number of residents cited:0 Based on observations, reviews of facility documents, and staff interviews, the facility failed to ensure that staff responsible for maintaining water temperatures were knowledgeable regarding acceptable hot water temperature ranges to ensure residents were free from potential burns. The facility failed to ensure water temperatures were monitored in residents' rooms / bathrooms prevent potential scalding of residents resulting in a finding of Immediate Jeopardy. The findings include: An observation on 8/7/2025 at 9:00 AM of the water temperature checked at the bathroom faucet shared by Residents #1 and #31 rooms initially read 130 degrees Fahrenheit(F) (Normal Range 110 to 120) then dropped down to 128 degrees F. The Administrator on the unit was asked to observe the temperature reading which identified the water temperature at the resident sink to be 128/127 degrees F. Further observation by the Administrator identified the water felt hot to touch. After the surveyor inquiry, the Administrator indicated he would inform Maintenance Director #1 immediately of the hot water temperatures. A request by the surveyor was made for the Administrator to obtain the facility's daily water temperature logs. An observation on 8/7/2025 at 9:10 AM in Resident #25 and #35's bathroom identified the water temperature was initially 128 degrees F then dropped down to 127 degrees F. An interview was conducted on 8/7/2025 at 10:00 AM with the Administrator, Maintenance Director #1 and the Director of Operations after surveyor inquiry, regarding the facility plan to safeguard residents, staff and visitors from using hot water until water temperature was within acceptable ranges to prevent potential burns. The Administrator indicated the Maintenance Director would immediately adjust the mixing valve and recheck temperatures. The Administrator indicated temperatures were within acceptable range having responded to the adjustment of the mixing valve. When the surveyor inquired about a copy of the temperatures taken, Maintenance Director #1 indicated she/he was unable to provide a copy as s/he did not write them down. Further inquiry into the facility's plan to ensure water temperatures remain in an acceptable range, ruling out a failure of the mixing valve, including staff awareness of the high-water temperatures as they provide care to residents in the facility identified no response. After a period of silence, the Director of Operations spoke up indicating an instant message would be sent to all staff immediately to inform them of the situation. At this time the surveyor again requested the daily water temperature logs to be provided. An interview and document review on 8/07/2025 at 12:50 PM with the Administrator identified logs labeled Water Management Plan, Hot Water Temps and Flushing in various locations throughout the facility taken monthly (one day) with the only resident locations being the 2nd and 3rd floor shower and tub rooms. The monthly temperature logs for January through April 2025 identified the resident areas the facility sampled for water temperatures were the 2nd and 3rd floor shower and tub rooms finding those and other non-resident locations requiring temperature monitoring and flushing for the water management plan were within acceptable temperature range (110-120 degrees F). The monthly logs dated 5/22/2025 through 7/18/2025 exceeded the acceptable water temperature limit which consisted of the following: temperatures on 5/22/2025 ranged from 127 to 130 degrees F, the temperatures on 6/19/2025 ranged from 126 to 132 degrees F, and on 7/18/2025 the temperatures ranged from 126 to 133 degrees F for 4 months without evidence of adjustment of the temperature and documentation of subsequent temperatures taken to indicate the effectiveness of adjustments to ensure water temperatures were safe for use to prevent scalding. The Administrator indicated in addition to instant messaging all staff, the staff on duty were in-serviced, water temperatures were taken of random resident bathrooms on 8/7/2025 at 9:55 AM subject to surveyor high water temperature readings. Further review of water temperatures identified the temperatures were all above 120 degrees F at 11:15 AM. However, after the mixing valve adjustment, water temperatures were identified within acceptable range (none above 120 or below 110 degrees F) After surveyor inquiry as to the facility's plan to monitor the ongoing effectiveness of the adjustment of the mixing valve in providing water at an acceptable temperature to prevent scalding, the administrator read the plan put in place which indicated checking random resident room water temperatures were to be taken each shift at a minimum of 5 times per week then 2 random resident rooms in each hallway to be monitored daily going forward. On 8/11/2025 at 8:40 AM an interview and facility document review of the facility water management plan with the Administrator and Maintenance Director #1 identified the Water Management Plan stated to prevent scalding, the temperature of the water was to be tested where the flow valve regulates the temperature. Review of the monthly water temperature flushing logs dated 5/2025 through 7/2025 with the Administrator and review of surveyor water temperatures

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab West Haven	308 Savin Avenue West Haven, CT 06516

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, facility policy and interviews for 1 of 3residents reviewed for respiratory care (Resident # 82), the facility failed to ensure the resident had current physician's order for oxygen therapy and for 1 of 3 residents reviewed for respiratory care (Resident #59), the facility failed to ensure that licensed staff appropriately evaluated a resident's oxygen as per professional standards during a potentially urgent medical situation. The findings included: 1.Resident # 82's diagnoses included acute respiratory failure with hypoxia, acute respiratory failure with hypercapnia and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #82 was cognitively intact and required supervision /set up assistance for personal hygiene, oral hygiene and partial assistance for bed mobility. A physician's order dated 5/16/25 directed to taper off oxygen gradually, maintaining oxygen saturation of >90 and to monitor every shift. A nurse's note dated 6/19/25 at 3:06 AM identified No shortness of breath or respiratory distress. Alert and oriented. No complaint of pain or discomfort. No signs or symptoms of hypo or hyperglycemia noted. Safety precautions maintained. Resident on supplemental oxygen via Nasal Canula. Call light within reach. A physician's order dated 7/2/25 directed to assess oxygen Saturation every shift and when needed assessment of respiratory status 3 times a day. A nurse's note dated 7/13/25 at 1:31 PM identified No signs or symptoms of cardiac distress. remain on oxygen via nasal canula, oxygen saturation currently 96%. Observations on 8/6/2025 at 12:43 PM of Resident #82 identified the resident in the room with nasal canula flowing at 1.5 L. While making the observation Resident #82 reported it supposed to be on 2. Observation on 8/7/2025 at 9:28 AM of Resident #82 on nasal cannula at a 1.5 L flow. Resident #82 reported he/she has been on oxygen since returning to the facility from the hospital (4/30/25). Review of the W10 (Intra- Agency Discharge Summary) indicated Resident #82 was admitted to hospital 4/20/25 due to (principal) Hypoxia Acute hypoxic respiratory failure. Resident #82 W10 physician's order indicated the resident requires oxygen due to diagnosis of severe lung disease or hypoxia liter flow of 2L continuous. Review of facilities electronic health records (EHR) and paper charts did not indicate an order for the oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with LPN #1 on 8/11/2025 at 9:56 AM identified all orders are placed in the EHR. She reported nursing team/ the nurse who is taking care of the resident at time of new physician's orders, is responsible for ensuring the orders are transcribed in EHR. LPN #1 reported the 11:00 PM- 7:00 AM shift is also responsible for checking residents' orders for accuracy. She is unsure why there is no oxygen physician's orders in Residents #82 records. Interview with DNS on 8/11/2025 at 9:58 AM indicated the liter flow is prescribed by the physician and documented in the facility computerized software. The DNS is unsure why Resident #82 was receiving oxygen without an active order in the EHR. After inquiry, a physician's order was created on 8/11/25 to identify liter Flow. Policy indicates in part A physician order is necessary for the admission of oxygen. 2. Resident #59's diagnoses included chronic obstructive pulmonary disease, asthma, and respiratory failure. A care plan revised on 4/9/2025 identified Resident #59 had recently experienced respiratory failure; interventions included providing oxygen as per the physician's orders and monitoring for signs of impaired oxygenation. The quarterly MDS assessment dated [DATE] indicated Resident #59 was cognitively intact and dependent for bed mobility and transferring. The MDS assessment further indicated Resident #59 was receiving oxygen therapy and non-invasive mechanical ventilation while a resident at the facility. On 8/6/2025 at 12:45 PM, Resident #59 was heard yelling for help. Upon the surveyor entering the room, the resident stated she/he was having difficulty breathing and appeared visibly short of breath with pursed lips and using accessory muscles to breathe. The surveyor went to the doorway and waved to LPN#1, who was exiting another resident's room at the opposite end of the short hallway. LPN#1 entered Resident #59's room and asked Resident #59 what was happening. Resident #59 indicated she/he needed to up the air. Resident #59 continued to appear short of breath with pursed lips and using accessory muscles to breathe. LPN#1 attempted to adjust the air flow from the resident's window air conditioner and then the resident's fan. While the resident's condition remained unchanged, LPN#1 indicated to the resident that she would return with something for her/his breathing. The surveyor remained in the room after LPN#1 had left the room and observed Resident #59's oxygen was not connected to the oxygen concentrator. From the doorway, the surveyor was able to notify a staff member; Speech Therapist #1 reconnected the resident's nasal canula to the oxygen compressor. At 12:50 PM, LPN#1 returned to the room with a pulse oximeter (a device to detect blood oxygen levels) and was notified that the resident's nasal cannula was disconnected from the compressor. Resident #59's pulse oximeter readings were an oxygen level of 87% and a pulse rate of 115 beats per minute. LPN#1 indicated the resident's goal pulse oximeter reading was greater than 90%. 0n 8/13/2025 at 10:16 AM, an Interview with the DNS indicated that when a resident on oxygen therapy is observed experiencing shortness of breath, the expectation is that the nurse evaluates the resident's oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 8/13/2025 at 12:11 PM an interview with LPN#1 indicated on 8/6/2025 when Resident #59 was short of breath and asking for more air she attempted to adjust the resident's window air conditioner and fan because those are the things the resident usually ask for from staff. When the resident has difficulty breathing the resident will usually say she/he cannot breathe. Additionally, LPN#1 indicated she may have seen the nasal cannula was connected when she picked up the resident's call bell from the floor. The facility policy and procedure manual for oxygen administration failed to identify any evaluation criteria for a resident experiencing shortness of breath and who receives oxygen therapy.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of Payroll-Based Journal (PBJ) staffing data and staff interviews, the facility failed to ensure sufficient nursing staff were available on weekends. The findings include: Review of PBJ data submitted by the facility identified weekend staffing levels were lower than weekday staffing during the following fiscal quarters: FY Quarter 4 of 2024 (July 1 -September 30, 2024) and FY Quarter 2 of 2025 (January 1-March 31, 2025). On 8/14/2025 at 11:07 AM, an interview with the facility scheduler identified the facility staffs appropriately but indicated that callouts may have made staff run short. The scheduler indicated when callouts occur, she will call staff to help cover. The scheduler further indicated that for a census of 83 residents (the facility census on the first day of survey), the facility schedules 3 LPNs for the 7-3 PM shift, 3 LPNs for the 3-11 PM shift, and 2 LPNs for the 11-7 AM shift. The facility also schedules one RN supervisor on each shift. For nursing aides, the scheduler indicated there are 10 nurse aides scheduled for the 7-3 PM shift, 8 aides for 3-11 PM, and 5 aides for the 11-7 AM shift. A review of staffing schedules for Sunday, 2/9/2025, with the scheduler, identified 11 nursing aides were scheduled for the 7-3 PM shift. However, for the 7-3 shift, there were 6 callouts from nursing aides, and the facility was able to call in one nursing aide. The 7-3 PM shift had a total of 6 nursing aides instead of 10. For the 3-11 PM shift on 2/9/2025, the facility had 8 nursing aides scheduled, but 5 nursing aides called out. The facility was able to call in 3 nurse aides, and one additional aide arrived at 9:30 PM. From 3:00 PM to 9:30 PM, the facility had only 5 nursing aides instead of 8. An interview with the scheduler indicated 2/9/2025 a snow day, and so the number of callouts was unusual. The facility did not provide documentation to demonstrate that resident care needs were being met despite the reduced staffing levels. A review of the staffing schedules for Saturday, 3/8/2025, and Sunday, 3/9/2025, identified on 3/8/2025, the census was 81 residents, and on the 7-3 PM shift, there were 11 nursing aides scheduled, but only 10 worked due to callouts. On 3/9/2025, the census was 83 residents, and there were 11 nursing aides scheduled, but only 10 worked due to callouts. A review of the Facility assessment dated [DATE] identified that the average daily census was 83 residents and the staffing plan called for 11 nursing aides for the 7-3 PM shift. The Facility Assessment further identified the weakness in the facility-based risk assessment was staffing, including a unionized workforce and limited per-diem/temporary licensed and unlicensed staff. On 8/14/2025 at 1:35 PM, an interview with the Administrator identified he was not aware the facility had been triggered for low weekend staffing in the PBJ report for FY Quarter 4 of 2024 and FY Quarter 2 of 2025. The Administrator indicated there can be call-outs, but the facility calls in staff to help when that occurs. The Administrator further indicated the facility is enforcing disciplinary actions related to callouts when appropriate. Additionally, the ADNS and DNS have worked to fill in as the RN supervisor; however, the Administrator indicated the DNS and ADNS would not have punched in when picking up shifts as direct-care staff. The Administrator also indicated that although the facility has contracted with a staffing agency in the past, it is not currently utilizing temporary/contract staff and had not utilized them in FY Quarter 4 of 2024 and FY Quarter 2 of 2025.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Observe each nurse aide's job performance and give regular training. Based on clinical record review and staff interviews, the facility failed to ensure that annual performance evaluations were completed for 1 of 3 nurses' aides (NA # 8) reviewed for performance evaluations and failed to provide regular in-service education based on the outcome of a performance evaluation. The findings include: Review of the personnel file for Nurse Aide #8 identified a hire date of 4/12/2024. As of the date of the survey (8/14/2025), there was no documented annual or earlier performance evaluation on file for Nurse Aide # 8. On 8/13/2025 at 2:13 PM, an interview and record review with RN#3 identified NA#8 had completed the required education on core competencies on 10/15/2024, which totaled 2 hours of training. However, RN#3 indicated NA#8 had not completed at least 12 hours per year of in-service education or education that addressed areas of weakness as determined in any performance review. On 8/14/2025 at 9:56 AM, an interview with the Human Resources Director identified NA#8 should have received an annual performance evaluation based on the hire date. The HR Director was unable to locate any documentation for a performance evaluation. An interview with the DNS on 8/14/2025 at 1:30 PM identified the DNS is responsible for completing performance evaluations for nursing aides. The DNS indicated that she was not in the DNS role at the time NA#8's performance evaluation was due and could not explain why it had not been completed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, review of policy and staff interviews for 2 of 2 medication storage carts (Unit 2 [NAME] and Unit 3 East), reviewed for medication storage, the facility failed to label open medications and discard expired medications appropriately. The findings include:Interview and observation with Registered Nurse (RN) #2 on 8/13/25 at 11:15 AM of unit 2-west medication cart identified the following: 1) Timolol Maleate Ophthalmic Solution 0.25%, 2 open bottles with no open date 2) Combigan Ophthalmic Solution, 1 open bottle with no open date 3) Dorxolamide Hydrochloride Ophthalmic Solution 2%, 1 open bottle with no open date 4) Infants Simethicone drops, 1 open bottle with not open date 5) Latanoprost Ophthalmic Solution, 1 bottle with open date of 6/6/25 6) Humalog/Lispro Kwik pen, 1 insulin pen with open date of 7/15/25RN #2 at the time of the observation indicated open medications should be labeled with open date and once they are opened, they expire 28 days later per policy. RN #2 identified that it is the responsibility of the nurse who opens the medication bottle to label it with the open and expiration date. The interview failed to identify why the open medication bottles were not labeled with open date and expiration date.Interview and observation with Licensed Practical Nurse (LPN) #1 on 8/13/25 at 11:51 AM of unit 3-east medication cart identified the following:1) Brimonidine Tartrate Ophthalmic Solution, 2 open bottles with no open date2) Restasis M multidose Ophthalmic Solution, 3 open bottles with no open date3) GeriCare Artificial Tears, 2 open bottles with no open date4) GeriCare Artificial Tears, 1 bottle with open date of 5/26/255) Sodium Chloride Hypertonicity Ophthalmic Solution, 1 open bottle with no open dateLPN #1 at the time of the observation identified open medications should be labeled with open date and expiration per policy and that it is the responsibility of the nurse who opens the medication to label with open date and expiration date. The interview failed to identify why the medication bottles were not labeled with open date and expiration date. Interview with the Director of Nursing (DNS) on 8/13/25 at 12:02 PM identified ophthalmic solutions and insulin pens expire 28 days after being opened, they should be labeled with the open date and expiration date by the nurse who opens the medication bottle and indicated it is the responsibility of the nurse who opens the medication bottle to label appropriately. The DNS indicated that once the medications expire, they should be discarded.Review of the storage and expiration dating of medications and biologicals policy, dated 6/30/25 directed that when an ophthalmic solution or suspension has a manufactured shortened beyond use date once opened, facility staff should record the date open and date to expire on the container.Review of the medication administered through certain routes of administration policy, dated 11/15/24 directed that eye medication bottles/tubes with accelerated expiration dates must be dated/initialed upon opening and to follow manufacture instructions or facility policy.

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Apple Rehab West Haven	308 Savin Avenue West Haven, CT 06516

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled for unnecessary medications: 5Number of residents cited: 1 Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #21) reviewed for unnecessary medications, the facility failed to ensure physician was aware of a pharmacy consultant's recommendation for laboratory monitoring. The findings include: Resident #21's diagnoses included atrial fibrillation (irregular heartbeat), dementia, hypertension (high blood pressure), heart failure, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 was moderately cognitively intact and required the assistance of 2 helpers for showering, personal hygiene, upper and lower body dressing, and transfers. The Resident Care Plan (RCP) dated 6/13/25 identified atrial flutter due to atrial fibrillation, an irregular heartbeat, at risk for heart failure. Interventions included to administer medications as ordered and adhere to parameters as ordered. The RCP dated 6/13/25 identified diabetes, at risk for hyperglycemia (too much sugar in the blood) and/or hypoglycemia (too little sugar in the blood) and interventions included to administer medications as ordered, labs as ordered and report abnormal to the Medical Doctor/ Advanced Practice Registered Nurse. A physician's orders; dated 12/15/21 directed to administer losartan potassium 1 tablet one time a day for hypertension (high blood pressure), dated 6/9/23 directed to administer metformin HCl 500 milligram (MG) one time a day for diabetes, dated 6/20/24 directed to administer Aldactone 1 tablet one time a day related to congestive heart failure, and administer torsemide 1 tablet one time a day for congestive heart failure. Review of monthly medications regime review and pharmacy recommendation consultation report for 6/27/25 on 8/12/25 at 10:20 AM, identified Resident #21 received metformin hydrochloride, Aldactone, losartan, and torsemide and pharmacy consultant recommended to check laboratory values for an A1c (measures the level of blood glucose over the past 2 to 3 months) and a bmp (Basic Metabolic Panel) on the next convenient lab day and every 6 months thereafter. Rationale for recommendation: metformin-containing medications have a BOXED WARNING (serious or life-threatening risks linked to medication) describing the risk of lactic acidosis (too much lactic acid builds up in the blood), which is increased with kidney disease. The recommendation consultation form was not signed by the physician and there was no order found in Resident #21's electronic health record. In an interview and clinical record review with the Director of Nurses (DNS) on 8/12/25 at 10:49 AM, the clinical record failed to reflect documentation of an order for A1c and BMP lab work. Further identified, pharmacy consultant recommendations are put in a book on the units by the DNS for the physician to review and either accept or deny recommendations. If recommendation is accepted an order is placed in the electronic health record, the physician signs the form and returns to the DNS, if denied, the physician writes their reason why, signs the form and returns to the DNS, the process has been back logged, since previous DNS had left in July 2025. Subsequent to surveyor inquiry, pharmacy recommendation consultation form was signed and dated by the physician, and an order placed in Resident #21's electronic health record on 8/12/25. Review of the Medication Regime Review Policy dated 12/1/07 directed, in part, the consultant pharmacist will provide the resident's monthly medication review (MMR) to facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations. _____ _____

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Apple Rehab West Haven	308 Savin Avenue West Haven, CT 06516

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and facility policy for 2 out of 32 opportunities observed during medication administration for 2 out of 5 Residents (#8 and #54) resulting in a 7. % medication error rate, the facility failed to ensure residents were free from significant medication errors due to no medication available for use and utilizing expired over-the-counter medication. The findings include: Resident #8's diagnoses included spina bifida, paraplegia, and stage 4 pressure ulcer of the sacral region. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 was cognitively intact and required the assistance of 2 or more people with bed mobility, toilet hygiene, and transfers. Observations of medication administration on [DATE] at 9:38 AM with Licensed Practical Nurse (LPN #1) for Resident #8 identified the clotrimazole-betamethasone cream was not available in the facility. Interview with LPN#1 on [DATE] at 10:29 AM identified Resident #8's clotrimazole-betamethasone cream was not located in the medication cart or in the medication room, and she would fill out a paper pharmacy re-order form and fax to pharmacy, and the cream should be delivered the next day. Interview on [DATE] at 9:35 AM with LPN #2 identified she was taking care of Resident #8 and administered her/his morning medications but could not locate the clotrimazole-betamethasone cream. LPN #2 placed a second pharmacy re-order request electronically through via computer. It was further identified the paper pharmacy re-order form for the cream was faxed to the pharmacy on [DATE] at 10:56 PM and would not be delivered until later in the afternoon on [DATE]. Interview on [DATE] at 10:36 AM with the DNS identified residents' medications should be re-ordered by the nurse when the quantity gets down to approximately a seven-day supply, and the medication would get delivered the same day if it was re-ordered or the next day, depending on the time of day requested. The DNS further identified, the physician should be notified when medications are not available or given to a resident. Review of Resident #8's Medication Administration Record (MAR) on [DATE] at 12:15 PM identified Resident #8 did not receive the clotrimazole-betamethasone cream and missed applications scheduled for [DATE] in the morning and in the evening and missed on [DATE] in the morning. Interview on [DATE] at 12:36 PM with LPN #1 identified that she filled out a paper medication re-order form for Resident #8's clotrimazole-betamethasone cream on [DATE] in the morning but did not fax it to the pharmacy until 10:56 PM on [DATE] at the end of her double shift. LPN #1 did not recall if the physician was notified. Interview on [DATE] at 2:05 PM with Person #3 identified the pharmacy received a paper re-order on [DATE] at 10:56 PM and another electronic re-order request on [DATE] at 9:38 AM and Resident #8's clotrimazole-betamethasone cream was delivered on [DATE] at 4:26 PM. Review of the Medication Administration Policy V1 dated 2025 directed, in part, the physician must be notified when a dose of medication has not been given, and an explanatory note is entered on the reverse side of the record provided when needed documentation. 2. Resident # 54's Diagnosis included Dementia and chronic kidney disease. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident # 54 was cognitively intact. The physician orders dated [DATE] directed to administer Citracal+D3 by mouth once daily for supplement (Multivitamin with minerals) one tablet by mouth daily. An observation on [DATE] at 09:32 AM during preparation of medications for administration to Resident #54 and interview with LPN # 5 at 09:34 AM after LPN #5 indicated placing one tablet of multivitamin with minerals into the resident med cup and placing the bottle on top of the medication cart next to other medication bottles for the surveyor to view, indicated after surveyor inquiry the facility policy for how long an over the counter medication can be used past the expiration date, indicated the medication only could be used until the beginning of the month of the date indicated. LPN # 5 began replacing the bottles of medications back into the cart without checking the expiration dates. Before LPN # 5 placed the bottle of Multivitamins with minerals completely back into the medication cart the surveyor intervened and asked LPN # 5 to check the expiration date which was 07/2025. Subject to surveyor inquiry LPN # 5 indicated needing to remove the Multivitamin with minerals from the medication cup and go to the supply room to get a new bottle. LPN # 5 then threw the bottle of the remaining expired Multivitamin and minerals into the trash on the side of the medication cart. After the other medications were administered to Resident # 54 and informing him/her of the need to obtain the medication and would return to provide it to the resident. LPN # 5 locked the medication cart and went to the supply room. At 09:50 AM while waiting for LPN # 5 to return from the supply room, the surveyor obtained the attention of the nursing supervisor RN # 4 who indicated the nurses check the expiration dates of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, facility documentation, and facility policy and staff interviews for 4 of 4 medication storage carts (Unit 2 East and [NAME] Wings) reviewed for medication storage, the facility failed to appropriately complete the controlled substance shift-to-shift reconciliation sign off sheet. The findings include:Interview and observation with Registered Nurse (RN) #2 on 8/13/25 at 11:15 AM identified the following:1) unit 2-east medication cart-controlled substance shift-to-shift sign off sheet was missing signatures for numerous shifts. Out of 186 possible signatures for the July 2025 controlled substance shift-to-shift sign off log, 31 were missing. Additionally, out of 74 possible signatures for the August 2025 controlled substance shift-to-shift sign off log, 20 were missing.2) unit 2-west medication cart-controlled substance shift-to-shift sign off sheet was missing signatures for numerous shifts. Out of 186 possible signatures for the July 2025 controlled substance shift-to-shift sign off log, 61 were missing. Additionally, out of 74 possible signatures for August 2025 controlled substance shift-to-shift sign off log, 12 were missing.RN #2 at the time of the observation indicated it is the policy for the unit nurse to conduct a controlled substance medication count with the oncoming shift nurse and each nurse will sign the log indicating the count is correct. Additionally, RN #2 identified that it is the responsibility of the off going shift nurse and oncoming shift nurse to ensure this is completed. The interview failed to identify why the signatures were missing. Interview and observation with Licensed Practical Nurse (LPN) #1 on 8/13/25 at 11:51 AM identified the following:1. unit 3-east medication cart-controlled substance shift-to-shift sign off sheet was missing signatures for numerous shifts. Out of 74 possible signatures for the August 2025 controlled substance shift-to-shift sign off log, 11 were missing.2. unit 3-west medication cart-controlled substance shift-to-shift sign off sheet was missing signatures for numerous shifts. Out of 186 possible signatures for the July 2025 controlled substance shift-to-shift sign off log, 20 were missing. Additionally, out of 74 possible signatures for the August 2025 controlled substance shift-to-shift sign off log, 9 were missing.LPN #1 at the time of observation identified she would normally sign the log at the end of shift for both spots but should sign at the beginning of shift and end of shift per facility policy. Additionally, LPN #1 identified it is the responsibility of the off going shift nurse and on coming shift nurse to ensure this is completed.Interview and observation with the Director of Nursing (DNS) on 8/13/25 at 12:02 PM identified the controlled substance shift-to-shift sign off logs were missing numerous signatures for all 4 medication carts. The DNS indicated that unit nurses should be counting each controlled medication at the end of shift with the oncoming nurse and they should be signing off on the log that it was completed. Additionally, the interview identified it is the responsibility of the unit nurses to ensure this process. The interview failed to identify why the signatures were missing.Review of the inventory control of controlled substances policy, dated 8/1/24, directed the facility should ensure that the incoming and outgoing nurses count all schedule two controlled substances and other medications with a risk of abuse of diversion at the change of each shift or at least once daily and document the results on a controlled substance count verification/shift count sheet.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record reviews, resident interviews, review of facility policy and staff interviews for 4 of 10 residents (Resident # 13, # 39, # 45 and # 81), the facility failed to ensure meals were served within 14 hours. The findings include:Resident #13 's diagnoses included anxiety, adjustment disorder and epilepsy. he quarterly Minimum Data Set assessment dated [DATE] identified Resident #13 was moderately cognitively impaired and requires set up assistance for eating.2. Resident # 39's diagnoses included Type 2 diabetes mellitus, hypertension and dysphagia.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #39 was cognitively intact and required set up assistance for eating.3.Resident # 45 's diagnoses included Type 2 diabetes mellitus, Gastro-Esophageal Reflux Disease without esophagitis and hypertension. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #45 was cognitively intact and required set up assistance for eating.4, Resident # 81 's diagnoses included anemia, localized edema and orthostatic hypotension.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #81 was cognitively intact and required set up assistance for eating.Review of facilities mealtimes indicated that dinner is served at 4:45 and Breakfast is served at 7:45am (15 hours apart). Interview with Residents #13, # 39, 45 and #81 on 8/11/25 at 10:43 AM indicated they do not receive a substantial snack between dinner and breakfast. Resident #13 reported the third floor does not get a snack cart daily. Resident #45 indicated if they do get a snack cart snack it only has crackers. He/she reported if he/she requests a sandwich he/she often gets push back from staff. Resident #39 reported that there is no peanut butter and jelly provided on the carts.Observation of the second-floor nourishment room on 8/11/25 at 1:23 PM identified juices, apple sauce and meals for other residents in the fridge. A snack box on the second floor had an assortment of crackers.Interview with Dietary Director Food Services on 8/14/25 at 11:21 AM indicated snacks go out to the units 3 times per day (after each meal). He reports the cart contains crackers, apple sauce and oatmeal cookies.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations of the kitchen, review of policy and staff interviews, the facility failed to ensure staff obtained ice in a sanitary manner in the kitchenette where the ice machine was not operational and the facility failed to ensure items in the kitchen were dated and labeled, dented cans were discarded, temperatures were consistently taken/ documented, and cleaning schedules were signed off on. The findings include: 1. On 8/7/2025 at 9:14 AM an observation of the kitchen identified the ice machine in the right corner of the room was pad locked and the wall mounted scoop holder was empty in the presence of the federal surveyor in attendance. LPN #2 entered the nourishment room and opened the freezer took out an ice cube tray (1 of four), with non-gloved hands, filled the tray with tap water and placed the ice cube tray into the freezer portion of the nourishment room refrigerator) further observation identified none of the ice cube trays had covers. Food items in a cloth bag were on the freezer shelf above the open ice cube trays and were labeled with a resident name and dated. An interview on 8/07/2025 at 9:15 AM with LPN #2 indicated the ice machine was broken for about 1-2 months but she/he was not exactly sure. The Administrator indicated the freezer had been broken for a few months, one was ordered and was scheduled to be delivered in a day or two. An observation of the freezer was again completed with the administrator and LPN #2 and the\ federal surveyor which identified ice cube trays noted and no other process for ice delivery. A facility policy was requested regarding use of ice cube trays in the nourishment room, but none was provided. 2. The tour of the Dietary Department on 8/6/25 with the Director of Dietary and cook #1 identified the following: The following items were identified with no dates or labels: Freezer 1 had a bag of brown dough like substances. Refrigerator #3 had 4 containers of red paste like substance, 2 containers of white substance, 1 container of meat, 5 containers of 3oz pureed substance. 3 sandwiches with brown and purple jellylike substance. Interview with cook #1 on 8/6/25 at 9:34AM indicated all items in the freezer and Fridges should be labeled with the date it was opened and the name of the items. He reported that all kitchen staff are responsible for ensuring this is done. [NAME] #1 is unsure why the aforementioned items are not labeled. Interview with the Dietary Director on 8/6/25 at 11:20 am indicated that all items in the fridge, freezer and storage areas should be labeled and dated. He reported that all kitchen staff are responsible for ensuring this is done. Facilities stock rotation policy indicates in part that All items need to be individually dated when removed from original containers. B. Walk through of the dry storage area on 8/6/25 at 9:40AM revealed the following can had a dent: 1 (6 pounds 9 ounces), Hunts Tomato sauce. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with cook #1 on 8/6/25 at 9:41 AM reported, all dented cans should be placed in a separate area and return to vendor. He reported that staff who are assigned stocking the dry storage are responsible for ensuring this is done. Facilities Damaged food containers policy indicated in part indicates angular dent with acute crimping of the body, wall or end seam should not be used . item should be removed from the storeroom and return to the vendor. C. Review of the food temperature log revealed that no temperatures were taken or documented for 7/16/25, 7/17/25 and 7/18/25. Interview with cook #1 on 8/6/25 at 9:58 AM indicated all cooks are responsible for entering temperature logs daily for food items. He is unsure why on the aforementioned dates has no temperatures recorded. Facilities Procedure for taking serving temperatures indicated temperatures should be taken when the food is placed in the steam table, no longer than 15 minutes before surveying. D. The weekly cleaning schedules that were provided do not indicate who is responsible for each task nor signatures indicating the task were done. Interview with the Director of Dietary on 8/6/25 at 11:38 AM indicated that he was not aware the cleaning logs needed to be signed.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on a review of the facility water management program, review of policy and interviews, the facility failed to ensure a policy and procedure for monitoring water temperatures to ensure temperatures are in acceptable ranges and process to follow with temperatures are out of range. The findings included: An observation on 8/7/2025 at 9:00 AM during checking water temperature in the bathroom faucet shared by Residents #1 and #31 initially read 130 degrees Fahrenheit(F) then down to 128 degrees F. The administrator on the unit was asked to observe the temperature reading, finding the water temperature at the resident sink to be 128/127 degrees F and it felt hot to touch. After surveyor inquiry, the Administrator indicated s/he would inform Maintenance Director #1 immediately. A request for the facility daily water temperature log was requested by the Administrator. An observation on 8/07/2025 at 9:10 AM in Resident #25 and #35's bathroom sink identified the water temperature was initially 128 degrees F then down to 127 degrees F. The surveyor requested several times for the facility policy and procedure for monitoring hot water temperature. However, the facility was only able to provide verbal instructions how they would follow up on the hot water temperature to ensure residents were free from scalding. Interview with the administrator at the time of the incident identified he would notify the Director of Maintenance who would notify staff the water was hot and maintenance would monitor hot water temperatures frequently until hot water temperatures are within normal range.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and staff interview, the facility failed to ensure the Quality Assessment and Assurance (QAA) Committee included required participants during scheduled meetings, as evidenced by missing signatures from key committee members on multiple dates. The findings include: Review of QAA Committee sign-in sheets from 10/7/2024 through 7/1/2025 identified on 10/7/2024, the sign-in sheet was missing signatures from the Infection Preventionist, Director of Nursing, and Medical Director. On 4/1/2025, the sign-in sheet was missing the signature of the Infection Preventionist. During an interview on 8/13/2025 at 3:45 PM, the Administrator identified the QAA committee met at least quarterly as part of their quarterly medical staff meeting. The Administrator could not identify why, on 4/7/2024, the Infection Preventionist, Director of Nursing, and Medical Director did not attend the meeting, as he was not the Administrator of the facility at the time. Additionally, the Administrator indicated the Infection Preventionist had not attended the 4/1/2025 meeting as there was no infection preventionist at the time. The facility policy for Quality Assurance Program identified the Quality Assurance committee is a multidisciplinary group consisting of the Administrator, DNS, Medical Director, the ICN (infection control nurse), and at least three other members.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interview for 1 of 2 residents (Resident #21) reviewed for pressure ulcers, the facility failed to ensure staff followed infection prevention and control practices during a wound dressing change for a resident with a pressure ulcer and the facility failed to ensure staff handled dirty linen in a sanitary manner in a shower area for 2 consecutive days, failed to ensure staff appropriately stored dirty linen bags in the laundry, failed to maintain clean wall fans and ceiling exhaust fans blowing toward clean linen areas, failed to maintain an adequate emergency linen supply, failed to maintain a clean, usable and easily accessible wash sink on the dirty side of the laundry, and failed to maintain a clean wash sink area with a wall surround on the clean side of the laundry and for the only resident reviewed for tube feeding (Resident #47), the facility failed to ensure that tube feeding was labeled correctly and discarded in a timely manner. The findings include: Resident #21's diagnoses included diabetes, heart failure, dementia, and personality disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 was moderately cognitively impaired and required assistance of 2 or more helpers with showering, personal hygiene, upper and lower body dressing, and transfers. The Resident Care Plan dated 6/13/25 and revised on 7/17/25 identified skin integrity at risk for skin breakdown due to decreased mobility, poor circulation, altered sensation and interventions included Rx (prescription or treatment) as ordered, and consult with wound care nurse specialist as ordered/needed. A physician's order dated 8/04/25 directed to apply Dakins soaked alginate, followed by ABD pad then gauze roll: two times a day for wound care. Observation on 8/12/25 at 11:14 AM of Resident #21's left heel pressure ulcer dressing change with Licensed Practical Nurse (LPN #2) identified LPN #2 entered Resident #21's room, closed the room door, opened the bedside table drawer, removed a bottle of Dakin's solution (antiseptic) and applied gloves without performing hand hygiene prior to donning gloves. At 11:18 AM LPN #2 removed Resident #21's soiled foot bandage and discarded it in the garbage, removed gloves and applied clean gloves without performing hand hygiene. At 11:21 AM LPN #2 removed gloves discarded the gloves in the trash, removed tape from her pants pocket, applied clean gloves without performing hand hygiene, and tore a piece of tape and placed it on Resident #21's foot dressing. LPN #2 did not follow infection control practices intended to prevent the transmission of infection. Interview with LPN #2 on 8/12/25 at 11:24 AM identified she should have sanitized her hands with Purell in between glove changes, and she should have cleaned Resident #21's tray table surface before she placed the clean dressing supplies on it. Although attempted, an interview with the Infection Preventionist was not obtained. Review of the Treatment Process Policy directed, in part, to clean the surface you are working on and to perform hand hygiene before every time you apply clean gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	_____ a. An observation on 8/6/2025 at 1:12 PM of the shower room on unit 3 found linens on the floor and balled up linen on a ledge in the toilet area, linen on the floor on the far shower stall with a bag under the shower chair, personal care items including shampoo, lotion, and a razor were noted along with a sign posted not to keep personal care items in the shower area. b. On 8/7/2025 at 8:45AM an observation and interview with the Administrator, LPN #2 and the federal surveyor identified the same linen on the floor in the far shower stall with a bag under the shower chair as noted the day prior when pictures were taken, the same personal items including lotions and soap remained. LPN #2 indicated the linens and personal care items should not be there and suggested the nurse aides were just in the shower room and had left them on the floor. LPN #2 further indicated s/he would obtain a bag to remove the linen and would also remove the personal care products. c. On 8/11/2025 at 09:15 AM interviews and observations with Laundry Worker #1 and #2 indicated both had been working at the facility for many years. Laundry Worker #1 indicated his/her work schedule was from 5:00 AM until 1:00PM and Laundry Worker #2 works from 3:30 AM until 11:30 AM. Both workers agreed there was a buildup of wet, clean linen in bins in the dirty linen area waiting to be dried. The two laundry workers indicated they have 2 washers and 2 dryers but one of the dryers broke a few weeks ago. Laundry Worker #2 indicated the one dryer makes the process slower, but the facility is able to supply linens for every shift and complete resident personal clothing. Laundry Worker #1 and 2 acknowledged the plastic wash sink in the dirty laundry had a large piece of the left front of the sink cracked off and dry supplies were located inside the sink. Bags of linen were on the floor in front of the access area to the sink, hooks and shelves above and to its side that contained personal protective equipment(goggles and gowns) and in front of the gown hung on a hook were bags of blankets the laundry workers indicated were now rags. Two bags of clean but wet linen were on the floor to the right side of the washer obstructing easy access to the sink/personal protective equipment. Boxes of disposable gloves were mounted on the back wall of the wash area and easily accessible. Below the gloves, 2 large open plastic bags that contained dirty linen was used to hold the sorted dirty linen before washing as indicated by Laundry Worker #1. Laundry worker #1 and #2 indicated the laundry area being very small has little to no storage especially when the laundry is backed up. The dirty linen area was noted to have a laundry chute with bags of dirty linen arriving into the bin every few minutes during the observation and Laundry Worker #2 indicated they have no choice but to place the dirty linen bags onto the floor when the 2 available bins fill and the laundry is backed up. Laundry Workers #1 and 2 indicated the corporate administration recently decided to stop using disposable wipes for incontinent care and disposable pads on the bed making the amount of dirty linen increase greatly. The two Laundry Workers indicated they, along with nursing staff, have had to throw away linen due to high soilage and the inability of the items to come clean enough for residents' use, further indicating the need to use the emergency supply of linens. The clean side of the laundry containing the dryers had a sink area alcove with a plastic material wall surround (on the sides and back of the sink area) had a white cloudy appearance built up which Laundry Worker #1 indicated does not come clean with wiping. The inside of the sink appeared dirty and a soiled broom and dustpan with thick layers of dust stood upright in front of the sink where the laundry workers indicated they use for hand washing. In front of the sink were two small rolling bins containing wet linens to go into the dryer which would need to be moved to access the sink area to wash hands or the broom and dustpan. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Observation of the emergency laundry supply with Laundry Worker #1 and #2 contained 12 packages of towels containing 2 towels each, about 11 or 12 knit bottom sheets, no washcloths, no top sheets, no pillowcases, blankets bed pads or bedspreads. Laundry Worker #1 and #2 indicated the laundry supervisor was aware of the need to use the emergency supply of linens. An interview and observation with the Director of Laundry on 8/11/2025 at 9:45 AM indicated a couple months ago one washer broke and it took a few weeks to replace, now a dryer broke a few weeks ago and a quote for a new and a refurbished dryer were obtained about 2 weeks ago. She also indicated she had not heard anything from Corporate since. Maintenance Director #2 joined the Director of Laundry with observations of the laundry areas with the surveyor pointing out the findings to Laundry Workers #1 and #2. The Director of Laundry indicated the Personal Protective Equipment could be moved to another location and the dirty fans are cleaned every so often by the laundry workers, but no sign off sheet or schedule could be provided. Maintenance Director #2 indicated there was very little room in the laundry area not allowing for proper storage of the linen when the laundry is backed up. After surveyor inquiry, regarding the dirty fans blowing toward the clean dryer area and the ceiling and wall intake and fans with dirt buildup, Maintenance Director #2 indicated the facility could clean all the fans and ceiling vents/intakes. The Director of Laundry indicated the sink area in the clean dryer portion of the laundry is wiped down by the laundry workers and the broom and dustpan with thick buildup could be cleaned by the laundry workers. On 08/11/2025 at 09:50 AM an interview and observation with the Director of Laundry and the federal surveyor in attendance indicated s/he would reach out to the Administrator regarding the progress with replacing/fixing the dryer and indicated s/he would be ordering more linens immediately having to increase the amount of linens purchased due to the wasted linens incurred with face cloths, towels and bed pads becoming too soiled with human waste to come clean. The Director of Laundry further indicated if both washers and dryers were in operating condition they could handle the increased supply of linens now needed, along with him/herself or another housekeeper working until 3:00 PM to finish any laundry to be meet the linen demands for the oncoming shifts. Resident #47 was admitted with diagnoses that included traumatic brain injury and epilepsy (a neurological disorder characterized by recurring seizures). The quarterly MDS assessment dated [DATE] identified Resident #47 had moderate cognitive impairment, was on a mechanically altered diet, and was not receiving nutrition through a feeding tube. A physician's order dated 7/11/2025 directed to administer Glucerna 1.2 (a type of nutrition) at 90 milliliters per hour (mL/hr) for 21 hours and remove per schedule. A physician's order dated 8/6/2025 directed to change and label gastric tube administration tubing and supplies once daily and as needed every night shift. An observation in Resident #47's room on 8/6/2025 at 12:28 PM identified a partially used tube feeding bottle hanging from an IV pole and connected to a feeding pump. The tip of the tubing was capped and not connected to the resident. There was no date, time, or feeding rate on the bottle to indicate how long the bottle had been opened or when it was first used. There was a partially filled water bag that was part of the feeding tube tubing system labeled 8/3 /25 4 AM. Additionally, the tubing of the feeding was labeled 8/6 with a piece of tape. Although the water bag and the tubing were part of one closed system, they contained different dates. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/2025, an interview with LPN #1 at 1:30 PM indicated that she did not know anything about the discrepancy in labels of the tubing and the water bag, nor did she know about why the tube feeding was not labeled or how long it had been hanging. LPN #1 indicated that she just knew that at 9:00 AM she turned the feeding off and that around 12:00 PM the tube feeding was due to be restarted. LPN#1 spiked a new tube feeding system and labeled it appropriately. On 8/13/2025 10:16 AM, an interview with the DNS indicated that tube feeding should be changed every 24 hours and the feeding bottle should be dated. Additionally, the DNS indicated that the water bag is part of and attached to the tubing system. The DNS could not identify a reason for a discrepancy in dates between the tubing and the water bag. A review of the facility policy for Enteral Feeding via Gastrostomy identified that the tube feeding bag (whether it's an open system or prefilled closed system) should be labelled with the resident's name, date, time, contents, rate of flow, and the nurse's initials.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075403	A. Building B. Wing	08/20/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, Review of the facility Infection Control Program, facility policy and interviews for 4 out of 5 residents reviewed for immunizations (Residents # 9, #63 # 67 #79), the facility failed to provide vaccines timely after consent was given and the staff failed to follow up with the responsible party of residents to offer vaccinations. The findings included: On 8/7/2025 starting at 02:00 PM and concluding at 4:30 PM the review of the facility infection control program was conducted by the surveyor with LPN #4, the Infection Preventionist, Corporate Nurse, RN #3 and the federal surveyor. A sample of 5 residents were reviewed for immunizations, and 4 out of the 5 residents were found out of compliance. 1. An interview and clinical record review for Resident #9 with LPN #4 identified a consent not signed with No, I refuse the annual influenza vaccine Pneumococcal vaccine and the Covid 19 vaccine. On the side of the consent form handwritten next to each vaccine type is written family deciding. At the bottom of the form there is no signature of the resident/responsible party or date, and at the very bottom of the form written is Awaiting family consent 10/3/2024, not indicating who wrote on the form. LPN #4 indicated the writing was hers and she had not reached out to the family after 10/3/2024 to obtain consent or declination for vaccine administration. LPN #4 was unable to locate written documentation of the initial call/conversation with the family member and indicated s/he should have followed up with the family.2, An interview and clinical record review for Resident #63 with LPN #4 identified Resident #63's family member had provided verbal consent for the Influenza, Pneumococcal and Covid19 vaccines on 3/10/2025, and the influenza and pneumococcal vaccines were not provided until 5/16/2025 (2.5 months after the resident provided consent to receive it). LPN #4 could not provide a reason for the delay in the provision of the vaccines and could not provide documentation regarding the reason for the delay. 3. An interview and clinical record review for Resident #67, admitted on [DATE], with LPN #4 identified a consent form for Resident #67 with handwritten dates LPN #4 indicated were the dates of Resident #67's last vaccine dates s/he wrote indicating the last Influenza vaccine was 1/05/2024, Pneumococcal vaccine 1/28/2019 and Covid vaccine was 9/30/22, which help to determine resident's eligibility for vaccines. Handwritten on the bottom of the form was the statement, conserved waiting for family member, without the date written or by whom. LPN #4 indicated s/he wrote on the consent form and was unable to provide any documentation of the date/time of a conversation with the family member or any further attempts to reach out for consent. 4, An interview and clinical record review for Resident #79, admitted [DATE], with LPN#4 found Resident #79 had provided consent to receive the Influenza, Pneumococcal and Covid vaccines on 7/22/2025. After surveyor inquiry, Resident #79 was provided the pneumococcal vaccine on 8/8/2025(17days after consent) and LPN #4 was unable to provide a reason for the delay in administering the vaccine. The facility policies labeled Influenza Policy indicated in part, the time frame for Influenza immunizations would follow the Centers for Disease Control (CDC) advisory committee on immunization practices, the medical staff director and availability of the vaccine. The policy further indicated the resident or legal representative would be educated on the risks and benefits of the vaccine on an annual basis. Documentation of refusals and re-offering the vaccine and consult would be completed as appropriate. The facility policy labeled Pneumococcal Vaccine indicated in part, the resident or responsible party would be offered the pneumococcal vaccine according to their specific eligibility that aligns with the current CDC Adult Immunization Schedule on admission. The facility staff would document refusal and re-offering/consult as appropriate. The facility policy labeled Covid-19 Vaccine Policy indicated in part, the resident or responsible party would be offered the covid-19 vaccine according to their specific eligibility, that aligns with the current CDC guidance. The facility staff would document refusal of the vaccine and re-offer/consult as appropriate.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of policy and interviews for 2 out of 5 residents (Resident #9 and Resident #63) reviewed for Immunizations, the facility failed to offer and Covid-19 vaccinations. The findings include:On 8/7/2025 starting at 2:00 PM and concluding at 4:30 PM during a review of the facility infection control program with the surveyor and LPN # 4, the Infection Preventionist, Corporate Nurse, RN #3 and the federal surveyor identified the following: A sample of 5 residents were reviewed for immunizations, and 2 out of the 5 residents were found out of compliance. 1 An interview and clinical record review of Resident #9, admitted on [DATE] with LPN#4 identified a consent form not signed by the resident or responsible party with a check next to the statement, no, I refuse the Covid 19. On the side of the consent form handwritten next to each vaccine type was written family deciding. At the bottom of the form there was no signature of the resident/responsible party or date and written at the very bottom of the form was awaiting family consent 10/3/2024 with no indication of who wrote on the form. LPN #4 indicated she/he wrote on the form and had not reached out to the family again after 10/3/2024 to obtain consent or declination for vaccine administration. LPN #4 was unable to locate written documentation of the initial call/conversation with the family member, could not provide a reason for the delay and indicated s/he should have followed up with the family resulting in the resident/responsible party not being provided the opportunity to decline or take advantage of the Covid- 19 vaccine. 2. An interview and clinical record review for Resident #63 with LPN #4 identified Resident #63's family member had provided verbal consent for the Covid-19 vaccine on 3/10/2025, and the Covid-19 vaccine was not provided until 5/16/2025 (2.5 months after the resident provided consent to receive it) leaving Resident #63 with no protection from the Covid -19 vaccine during the 2.5-month time period. LPN #4 could not provide a reason for the delay in the provision of the vaccine and could not provide documentation regarding the reason for the delay.The facility policy labeled Covid-19 Vaccine Policy indicated in part, the resident or responsible party would be offered the covid-19 vaccine according to their specific eligibility, that aligns with the current Center for Disease Control (CDC) guidance. The facility staff would document refusal of the vaccine and re-offer/consult as appropriate.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview for 1 of 4 residents reviewed for the environment (Resident #59), the facility failed to ensure the resident call system was accessible to a resident in their room. The findings include: Resident #59's diagnoses included chronic obstructive pulmonary disease, asthma, and respiratory failure. The quarterly MDS assessment dated [DATE] indicated Resident #59 was cognitively intact, required set-up assistance for eating, was dependent for bed mobility, and transferring. During initial screening on 8/6/2025 at 12:35 PM, Resident #59 was observed in bed facing the right side of the bed towards the window. The call bell was observed lying on the floor on the left side of the bed, out of the resident's reach. The resident indicated she/he uses a call bell when she/he needs it but did not know where it was in that moment. After screening the resident, the surveyor left to search for a staff member to observed observe the call bell. At 12:45 PM, before encountering a staff member, the surveyor, who was in the hallway, heard the resident yelling for help. Upon entering the room, the resident stated she/he was having difficulty breathing and appeared visibly short of breath with pursed lips and using accessory muscles to breathe. The surveyor went to the doorway and waved to LPN#1, who was exiting another resident's room at the opposite end of the short hallway. LPN#1 entered the room and attended to Resident #59. As LPN#1 was leaving the room, the surveyor pointed out to LPN#1 the call bell continued to be on the floor, inaccessible to the resident. LPN# 1 placed the call bell back on the resident's bed. On 8/6/2025 at 12:50 PM, an interview with NA#14, who was assigned to Resident #59 that day, indicated that she did not know why the resident's call bell was on the floor and out of reach. NA#14 indicated call bells are usually clipped or wrapped onto the bed. A review of facility policy for Call Bells indicated that call bells should be positioned so residents can easily access them when needed.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility employee education training records and staff interview for 5 of 5 training records reviewed (NA#9, NA#10, NA#11, NA#12, and NA#13), the facility failed to ensure that nurse aides received at least 12 hours of in-service training annually. The findings include:On 8/14/2025 at 2:13 PM, an interview and record review with RN#3 identified staff members participate in an annual skills day that takes 2 hours. RN#3 indicated there are also modules that staff take to add additional training time. Five nurse aide training records were reviewed with RN #3, and the following were identified: NA#9 (date of hire: 3/28/2024) had 3 hours of in-service training documented, including 2 hours for yearly skills day and 1 hour of dementia training. NA#10 (date of hire: 9/18/2024) had 4 hours of in-service training documented, including 2 hours of skills day and 2 hours of dementia training. NA#11 (date of hire: 1/30/2024) had 2 hours of in-service training documented for skills day. NA#12 (date of hire: 8/2/2024) had 2 hours of in-service training documented for skills day. NA#13 had zero hours of in-service training documented.During the interview, RN#3 indicated the training records reviewed were complete and acknowledged that none of the five nurse aides had documentation of the required 12 hours of annual in-service training.RN#3 indicated the training was made available, but not all staff completed it.